9/22/10 #1

Testimony: Governor Quinn Administration's Implementation Council
DATE: September 22, 2010
RE: Jim Duffett, Campaign for Better Health Care

Good Afternoon:

My name is Jim Duffett and I am the Executive Director of Campaign for Better Health Care, CBHC is Illinois' largest health care reform coalition representing hundreds and hundreds of diverse organizations throughout the state and thousands of individuals.

I'd like to stress a couple points pertaining to the topic at hand as the Quinn Administration moves forward with implementing the new health care law that will finally give Illinoisans **peace of mind** and once and for all – **NOT Any Longer** will the discriminatory practices of the insurance industry be allowed.

First – there is no reason that the State of Illinois and the General Assembly needs to wait to implement a number of reforms. For example:
a) While *ending the discriminatory practice of denying insurance due to pre-existing conditions* for children age 19 and younger becomes illegal at midnight tonight, for individuals 20 to 64 this discriminatory practice will still be legal until 2014. Illinois should end this practice NOW. Waiting will only add to the financial and health care hardship of Illinois families and add more debt to the provider community. There are other measures that we will provide you that can occur quicker then waiting until 2014. We need fairness and a level playing field.

Second - *Medical Loss Ratio:* This terms means the amount of premium that will be applied to providing medical/health treatment for an individual. While the overall standards will be set by HHS, Illinois must go further. Under the current national health care law, MLR for group plans must be 85% and for individual plans it must be 80%. If the federal Medicare program's MLR is 97% and the state's MLR for Medicaid is 93%, Illinois should embark on a gradual increase of at least 95% for all plans operating in the exchange by 2016. A nation report released in May of 2010 showed that the five largest for-profit insurance companies, who all operate in Illinois, reported a combined

net income of $3.2 billion, a 31 % leap from the same period in 2009. This occurred during the worst economic downturn since the Great Depression.

Third - *Rate Review*: Last year before the federal reform was even passed the insurance industry claimed their double digit rate increases were due to the "pending" health care reform legislation. Now they are claiming that their double-digit rate increases are because of the national law that passed. Enough of the whinning. We urge the Quinn administration to provide the Department of Insurance with broad and strong powers for full transparency of all insurers conducting business in our state and for DoI to review all proposed rate increases by the insurance industry, and ultimately through a public process either deny, agree, or readjustment these rate increases to protect small businesses and working families throughout our state.

Fourth - *Insurance Exchange:* Yesterday, CBHC and U.S. Senator Richard Durbin released a report commissioned by Families USA that showed at least 1,059,100 Illinoisans will be eligible for the federal tax credits in 2014 that would occur within the health insurance exchange. As the state of Illinois moves forward in the development of the insurance exchange, we believe several components need to be included. We will provide a longer list of these suggestions, but today I will only highlight a handful:

- **The development of a public option:** Competition is good and healthy. Currently two Illinois insurers (Blue Cross and Blue Shield – 47% and Well point – 22%) control 69% of the state's commercial market. There is no competition. Illinois families and small businesses must have real choices. This would help promote value and cost effectiveness within the Exchange.

- There is a federal requirement for states **to consult with consumers** and other stakeholders on Exchange design. Consumers must be represented in a meaningful way in this process. (The renewal of Exchange grants to states is conditional on demonstrating formal participation by consumer advocates.)

- **Governance** of the exchange should also include key stakeholder-beneficiaries: labor, consumer, business, but should exclude direct participants in the system (who have conflicts of interest) – insurers.

- An Exchange can only hold down insurer costs if it has market authority — and to have this, the Exchange needs to cover a significant share of people. It's important to **broaden, not carve up, insurance markets** to provide Exchanges with enough covered lives to be able to negotiate good prices and coverage with insurers. This may be one reason to combine individual and SHOP Exchanges, or to consider a regional Exchange.

• **Quality and value of health plans** must be measured and made public. The Exchange could consider factors such as premiums and rate increases, quality measures such as HEDIS scores and NCQA measures and implementation of payment mechanisms to reduce medical errors and preventable hospitalizations, reduce disparities, and improve language access.

• Reducing adverse selection (keeping similar insurance rules in and out of Exchange)

• Help with consumer information and enrollment, especially through Navigators

• Oversight of premium increases, marketing and profits of insurers

• Integration with Medicaid to maintain continuous coverage

• **Creating of standardized plans** (it may be helpful to group plans by criteria beyond actuarial value) to facilitate consumer choice of health plans.

• The Exchange should **provide easy-to-understand information** about health plans that helps people make informed choices about their coverage, and the web portal should facilitate easy comparisons.

• The web portal should create greater administrative ease in purchasing insurance through transparent information, and allow for "one-stop shopping" for consumers.

• The law defines the levels of coverage through "tiers" based on actuarial values to facilitate comparisons by consumers. However, using actuarial values as a way to standardize plans still allows for major differences in benefit limits and cost-sharing (even among plans in the same tier) and makes comparisons difficult for normal people.

Navigators are created in Section 1311(i) of the ACA. Navigators are funded by Exchanges to help provide information and assist consumers and small businesses with enrollment in health plans.

• It may be helpful for web portals to provide further information on plans beyond actuarial value, such as specific health services provided and examples of cost sharing.

• The web portal should consider language access and consumers with low literacy levels.

• Value-based purchasing consistent with limits defined by HHS should also be considered provided that cost-sharing does not create barriers to treatment for lower-income enrollees.

• **Provider payment policies** for Exchange plans should be reasonable related to the cost of providing high quality care. No cut rate reimbursements.

• The Exchange should negotiate with insurers, including oversight of premium increases, marketing and profits. To monitor the impact of these requirements, Exchanges should collect data on compliance and make this information available to the public.

• Information on Exchange plans is required to be linguistically and culturally competent, and should meet the federal government's standards,

• Navigators are required by ACA to be **culturally and linguistically competent.**

• It is critical to provide outreach and enrollment support, especially targeted to vulnerable communities to help them enroll in Exchange plans.

• Navigators based out of consumer assistance programs and based in consumer health advocacy or community groups have experience working with vulnerable populations and would be critical to the Exchange.

• The certification criteria should consider: medical loss ratios, premium increases, consumer input and representation in health plans, and quality rating standards, such as HEDIS measures and NCQA standards. Also, require payment mechanisms to reduce medical errors and preventable hospitalizations and also strategies to reduce disparities.

• An Exchange should **require health plans to show an ongoing, formal process for consumer input in the health plans**. For instance, plans should create an independent enrollee organization and ombudsman program accountable to members rather than the plan management.

• The law requires the Exchange to provide **information on cost-sharing to consumers,** including scenarios for out-of-pocket costs for certain common procedures. Consumers should have input in the development of this information, which should be presented in lay language.

• The key principle that should govern decisions about the coordination between Medicaid, CHIP, and the Exchanges should be the creation of a **"no wrong door" system of enrollment**. This means that a streamlined application form and eligibility process should be put into place that will allow consumers to seamlessly access whichever program they are eligible for, regardless of their initial application.

• Both the Exchanges and Medicaid and CHIP rules and verification requirements should be aligned as much as possible. Consumers are likely to move from Medicaid to subsidized Exchange plans as their income fluctuates, and eligibility systems need to make this process as seamless as possible.